

the drug lessens the intensity of the dysmenorrhœa. (4) If one administers aspirin shortly before menstruation the dysmenorrhœa will be suppressed. (5) Aspirin has a beneficial influence upon amenorrhœa and menorrhagia. Chidichimo, himself, finds that aspirin slows uterine contractions and exercises an analgesic effect. It is not excreted in the milk of nursing women. It causes diminution of pain in the genital apparatus, whatever its cause may be. The usual dosage is 10 to 15 grains, two or three times daily. The drug is said to have no disturbing effect upon the stomach or kidneys nor does it cause headache or tinnitus.

The Specific Treatment of Tuberculosis.—H. HOCHHEIM (*Zentralbl. f. die Gesamte Therapie*, 1906, No. 8, p. 393) concludes a paper upon this subject with the following *resumé*: In the treatment of phthisis we have no certain therapeutic agent; the treatment of the disease is tedious and requires much patience both in physician and patient. One of the most approved means of treatment is the administration of thiocol (potassium sulphoguaiacolate), which may be given in powder, capsules, or solution, in daily dosage of about 30 grains. The drug is tasteless and has no disturbing effect upon the stomach. Its particular disadvantage is its costliness.

The X-rays and Resorcinol in Lupus.—S. EHLMANN (*Sem. med.*, 1906, No. 37, p. 439) reports excellent results from the combination of these two agents. His technique is as follows: First, a dressing impregnated with a 33 per cent. resorcinol ointment is applied; this is removed after about twelve hours and the lesion is curetted with a sharp spoon, or a tampon wet with mercuric bichloride solution is applied. The procedure is repeated after four or five days, and x-ray treatment is begun. The resorcinol applications are continued at intervals. Later, dressings of boric-acid ointment are applied, and, after a time, the treatment above described is again instituted. The cycle is continued until cure is completed, which is usually accomplished in from two to seven months.

PEDIATRICS.

UNDER THE CHARGE OF

LOUIS STARR, M.D., AND THOMPSON S. WESTCOTT, M.D.,
OF PHILADELPHIA.

The Influence of Vaccination upon the Evolution of Infectious Diseases.—L. JESIERSKI (*Jahr. f. Kinderheilk.*, 1906, xiv, 337) details some interesting observations upon this point, made possible by the occurrence of smallpox in a hospital ward containing scarlatina patients. A child aged eight years, suffering from scarlet fever, presented a smallpox eruption ten days after admission to the ward. In consequence, all

of the children in the service were at once vaccinated; these embraced 22 scarlatinous, 10 tuberculous, 1 leprous, and 5 typhoid patients. Of the 22 scarlatinous, 11 were more or less severely disturbed by the engrafted vaccinia: with some the evolution of the scarlatina was prolonged, while with the others various complications were noted. None of these children had been previously vaccinated. In the remaining 11 patients, 6 of whom had been previously vaccinated, vaccinia seemed to produce no disturbance. Of the 10 tuberculous patients, 1 alone presented any abnormal phenomena. Among the 5 typhoids, all of whom were convalescing, 4 presented no unusual disturbance; in the fifth, however, there was a marked infiltration of the arm with a temperature rise to 102.6°, which became normal on the fifth day. In the leprous patient, a boy aged seven years, vaccination produced no complication. It is interesting to note that in the contents of the vaccinal pustule *lepra bacilli* were present.

Congenital Rachitis.—MARFAN (*Semaine med.*, 1906, No. 41, p. 481) concludes a study of congenital rachitis with the following propositions:

1. There is a congenital rachitis latent at birth, or only to be detected by microscopic examination. In these cases the bony deformities are not appreciable until some time after birth. Whether this form can be distinguished from an early acquired rachitis by any definite sign is not known; but when a rachitis begins very early with craniotabes, and when the softening of the cranial bones is clearly appreciable before the fifth or sixth week, it seems probable that the disease began before birth.

2. A certain number of infants affected with congenital rachitis are born dead or non-viable. It is among these that cases of excessive osseous deformity are found; these are observed by the accoucheur during parturition and are often accompanied by visceral malformations. As pointed out by Porak and Durante, we now know that even in these cases of excessive deformity the clinical diagnosis is not always possible; that micromelia is not necessarily a distinctive feature of achondroplasia, but may exist also in periosteal dysplasia and in rachitis, though inconstant in the former and rare in the latter; and that it is sometimes necessary to employ the microscope and x-rays in order to distinguish these osseous dystrophies.

Two forms which especially interest the physician are those in which congenital rachitis, evident at birth, is compatible with life and continues to develop after birth, and in which the evolution demonstrates the nature of the osseous alterations observed at birth. Typical examples of these forms are furnished by the cases reported by Marfan.

3. In the one representing the rarest condition the skeletal deformities are from birth so extended and so characteristic that, though slight, one cannot mistake their nature: enlarged cranium, with prominent forehead and jutting bosses, enlarged fontanelles, and often separated sutures, distinctly enlarged costal nodosities, enlarged epiphyses, and curved diaphyses. If the child is carefully guarded and escapes serious infections the deformities show little increase, becoming slightly accentuated after birth, then remaining quiescent for a long time, and finally disappearing toward the end of the second year.

4. In the second form of the disease there is at birth craniotabes, either alone or associated with a slight costal rosary. Differing from the preceding form, the rachitis here progresses after birth, as if, at the time of parturition, it was in its first stage; later on one sees characteristic deformities of the cranium, thorax, and limbs develop. At the same time, as in the preceding case, if the child is well cared for and escapes serious infections, the rachitis remains quite slight in degree and disappears without leaving decided deformity. As common characteristics of these two forms, Marfan states that such children are born most frequently before term, are below normal weight at birth, and present, in the course of the first two years of life, an anemia more or less profound.

Perforating Scarletinal Angina.—GUINDESSE (*Semaine med.*, 1906, p. 138) has observed three cases of primary perforating angina in the course of scarlet fever, which presented some analogies with the perforations of the uvula lately described by Méry and Hallé.

In the first case, a girl aged fifteen months, admitted to the hospital on the fifth day of a grave scarlatina, there were already at the time of admission two perforations symmetrically situated in the anterior pillars, having the form of longitudinal slits about 0.5 cm. in length, with smooth edges of deeper color than the surrounding tissues. The child died, after eight days, of septicemia.

The second case was that of a boy aged five years, admitted to the hospital on the third day of a particularly benign attack of scarlatina. As the result of a necrotic process affecting the uvula and developing after admission, a complete perforation occurred about the end of the second week. There was little tendency to healing and the perforation remained, though somewhat diminished in extent, at the end of fifteen days, when the child was removed from the hospital. The third observation concerns a girl of eleven years, with whom the disease was complicated from the beginning with diphtheria, and the perforation observed later in the anterior pillar could perhaps be attributed to the latter disease; but since it persisted at the end of three weeks, when there were no traces of diphtheria remaining, it is likely that here again the perforation was primitive. Contrary to the observation of Méry and Hallé, perforating angina was not accompanied, in Guindesse's cases, either by a general reaction particularly marked, or by phenomena of local inflammatory reaction; the temperature was not greatly elevated, and there was no submaxillary adenopathy.

Guindesse does not consider perforative angina as indicating necessarily a severe prognosis; it may occur with mild infections as well as with the severer forms. Perforation, however, being the consequence of penetration of the streptococcus deep into the tissues, should be considered as one of the manifestations of a general streptococcic infection, and, as such, increases in a certain degree the gravity of the prognosis.